EXHIBIT 1

FMLA #1 New Year

HRB LABOR ROUTING INFORMATION SHEET

Date: March 20, 2020

Division / Facility: HRB/ASD

Email to: Jeremy Rodriguez-Ortega

cc: Melton Young bcc: _____

Documentation for: (FML) ALD LWOP

HRB Staffed: (DR) MY JRO DS FM

Employee Name: Jeremy Rodriguez-Ortega

(Approved) Disapproved

FML Request # 1 (New Year) Continuous (Intermittent)

~~ALD Request #~~ _____

~~LWOP Request #~~ _____

Dates: July 9, 2019 through July 8, 2020

Additional Information: Approved Intermittent use of self 24/7 coverage for flare-ups and appointments, therapies as needed. All prescheduled appointments must be provided to mgr./supv. at least 3 business days in advance.

Contact Daisy R. with Questions

New Year of FMLA

NEW MEXICO DEPARTMENT OF HEALTH

FMLA #1

FAMILY AND MEDICAL LEAVE REQUEST

GENERAL PROVISIONS:

a. Employee must request Family and Medical Leave (FMLA) thirty (30) days in advance or as soon as practicable under the facts and circumstances of the particular case.
b. Employees who have been in either classified or exempt service for at least 12 months and who have worked for at least 1250 hours during the last 12 months are entitled to leave under FMLA.
c. FMLA may be requested for the care of the employee's child (birth, or placement for adoption or foster care); for the care of the employee's spouse, son or daughter, or parent, who has a serious health condition; or, for a serious health conditions that makes the employee unable to perform their job.
d. A serious health condition includes conditions or illnesses affecting one's health to the extent that inpatient care is required as well as absences necessary on a recurring basis or for more than a few days for treatment or recovery. In the absence of inpatient care, a serious health condition will require more that 3 days of illness and continuing treatment by a health care provider.
e. A Certification of Health Care Provider from or other documentation as appropriate will be required when making request.

EMPLOYEE NAME: Jeremy Rodriguez-Ortega EMPLOYEE ID# 110055

Division or Facility where employed: NMDOH/ASD/HRB Hire Date: at the state of NM

Is your spouse employed by a State Agency or the Department of Health? Yes_____ No ✓

If "YES", please complete items (a) through (c):

a. Name of Spouse:_____ Employee ID#_____

b. Agency, Division or Facility where employed:_____

c. Will your spouse also request or has your spouse requested FMLA leave for the same reason/health condition for which you are requesting FMLA leave? Yes_____ No_____

REASON FOR REQUESTING FMLA LEAVE:

Place a check in the appropriate space below and ATTACH APPROPRIATE DOCUMENTATION TO SUPPORT REQUEST:

_____To care for my child after birth or _____placement for adoption, or _____foster care

_____To care for my spouse. _____To care for my domestic partner. _____To care for son or daughter.

_____To care for a parent. _____To care for a person in loco parentis. ✓ Personal Illness.

LEAVE REQUESTED: (THIS MUST BE COMPLETED BY THE EMPLOYEE)

a. Indicate type of leave requested:

✓ Annual Leave ✓ Sick Leave

✓ Unpaid Leave ✓ Personal Leave

✓ Compensatory Leave

b. Will leave be continuous _____ Intermittent ✓ or reduced work schedule_____

c. Leave dates: From July 9, 2019 To July 8, 2020

Recommended that Jeremy should be on 24/7 intermittent FMLA to account for any type of frequency and duration for appointments, therapie and treatments as needed. This would also allow him to work as able and invoke FMLA as needed for appointments and flare-ups for medical reasons.

EMPLOYEE SIGNATURE: Jeremy Rodriguez-Ortega 3/20/2020 DATE:_____

12 MONTH FML START DATE: New Year of FMLA FML HOURS USED: 0

Does employee qualify for FMLA Leave? YES Yes NO

HR ACKNOWLEDGEMENT OF REQUEST: [signature] DATE: March 4, 2020

(FOR HRB USE ONLY)

LABOR RELATIONS MANAGER APPROVAL: [signature] DATE: March 18, 2020

ALL SECTIONS OF THIS FORM MUST BE COMPLETED

Revised 11/14/14
FMLA Request

NMDOH Rodriguez-Ortega No. 0332

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

WHD
U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 8/31/2021

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: Jeremy Rodriguez-Ortega

Date: 3/20/2020

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.
We received your most recent information on 3/16/2020 and decided:

✓ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

N/A Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: N/A

✓ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period). Intermittent 24/7 FMLA leave Approved March 18, 2020

Please be advised (check if applicable):

✓ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement. Or unpaid FMLA

N/A We are requiring you to substitute or use paid leave during your FMLA leave.

N/A You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ___ is ___ is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

___ **Additional information is needed to determine if your FMLA leave request can be approved:**

___ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____ (Provide at least seven calendar days), unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

___ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

___ Your FMLA Leave request is Not Approved.
___ The FMLA does not apply to your leave request.
___ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.

Form WH-382 January 2009

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: The New Mexico Department of Health / SoNM

Employee's job title: H.R. Labor and Trning Spec-A Regular work schedule: 7:30 to 4:30 1 hour lunch

Employee's essential job functions: all HR functions related to labor.

Check if job description is attached: ____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: JEREMY (First) E, (Middle) RODRIGUEZ-ORTEGA (Last)

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: Thomas Longley MD
PMG St. Michael's
454 St. Michael's Drive
Santa Fe, NM 87505
O (505)303-6000
Fax-(505)473-0375

Type of practice / Medical specialty: ____

Telephone: (____) ____ Fax: (____) ____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 1/2017

Probable duration of condition: Unknown ? LIFE?

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No __Y__Yes. If so, dates of admission:

2/5/20, 2/21/20

Date(s) you treated the patient for condition:

1/2016 ? present

Will the patient need to have treatment visits at least twice per year due to the condition? ___No __Y__Yes.

Was medication, other than over-the-counter medication, prescribed? ___No __Y__Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
___No __Y__Yes. If so, state the nature of such treatments and expected duration of treatment:

Nephrology, GI, specialty consult + treatment recommendations ? duration - >1 year

2. Is the medical condition pregnancy? __N__No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: __Y__ No ___ Yes.

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Patient with chronic pancreatitis of unclear etiology requiring frequent ER/office visits, intractable n/v profound weight loss

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? X No ___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No X Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___No X Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

1-2x/week, 4-8 hours/visit

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No X Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?
___ No X Yes. If so, explain:

Unable to work during flares

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: 1-2 times per 1 week(s) _____ month(s)

Duration: _____ hours or 1-2 day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

3/13/20

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Notice of Eligibility and Rights & Responsibilities (Family and Medical Leave Act)

U.S. Department of Labor
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1235-0003
Expires: 8/31/2021

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

[Part A – NOTICE OF ELIGIBILITY]

TO: Jeremy Rodriguez-Ortega
Employee

FROM: David Rich, Labor Mgr.
Employer Representative

DATE: March 4, 2020

On March 4, 2020 you informed us that you needed leave beginning on July 9, 2019 for:

___ The birth of a child, or placement of a child with you for adoption or foster care;

✓ Your own serious health condition;

___ Because you are needed to care for your ___ spouse; ___ child; ___ parent due to his/her serious health condition.

___ Because of a qualifying exigency arising out of the fact that your ___ spouse; ___ son or daughter; ___ parent is on covered active duty or call to covered active duty status with the Armed Forces.

___ Because you are the ___ spouse; ___ son or daughter; ___ parent; ___ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

Yes, Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)

___ Are not eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):

___ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately ___ months towards this requirement.

___ You have not met the FMLA's hours of service requirement.

___ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact Melton Young, FMLA Coordinator or view the FMLA poster located in @ (505) 827-2543.

[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by** March 19, 2020. (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

✓ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request ✓ is/___ is not enclosed.

___ Sufficient documentation to establish the required relationship between you and your family member.

___ Other information needed (such as documentation for military family leave): _____

No additional information requested

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3/4/2020
DR reviewed. Mr. Rodriguez-Ortega is eligible for a new FMLA year starting retro-actively back to the beginning of his new FMLA year (July 9, 2019 through July 8, 2020).
Measured regular hours worked from 7/9/2018 through 7/8/2019 (the year preceding start date of new FML year.

HRB Labor
3/4/2020

GINA (Genetic Information Nondiscrimination Act)

Title II of the Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to a request for medical information. "Genetic information," as defined by GINA, includes an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member and genetic information of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Jeremy Rodriguez-Ortega 3/16/2020